HOSPITAL: _____

MANUAL REFERRAL LETTER – PMNHIP

STATE LIFE
INSURANCE CORPORATION OF PAKISTAN

VISIT ID: _____ **DATE:** _____

PATIENT:
CNIC:
RELATION:
GENDER
DOB:
MARTIAL STATUS:

Card NO:
Family Head:
CNIC:
Contact No:
Attendant Name:
& Relation:

Presenting Complaints:

_____

_____

History:

_____

_____

Examination:

Pulse	Respiration	Temperature	Blood Pressure

Investigation:

_____

_____

Diagnosis:

_____

OPD: ☐ OPD ☐ ☐ ☐

Follow up Ante-Natal

Referred

Admission:

☐ Surgical ☐ Maternity

Non-Surgical/Per Day

☐ Hepatitis ☐ Diabetes ☐ Pyrexia ☐ Dialysis

Other: _____

Procedure / Treatment:

_____

Expected Length of Stay _____ **Days**

Date: ____ - ____ - _____

_____

Attending Physician Name / Sign

HOSPITAL: _____

ADDRESS: _____

Manual Case Sheet

Date & Time: _____

STATE LIFE
INSURANCE CORPORATION OF PAKISTAN

Head of Family : _____
CNIC # : _____
Contact # : _____
Card # : _____
Mohallah / Street: _____

Visit # : _____
Date # : _____
Program # : PMNHIP

Village: _____
Union Council: _____
Tehsil:_____
District: _____
Province:_____

Patient	CNIC #	Contact #	Relation	Gender	Martial Status

SP

Treatment/Procedure

Coverage Doctor	Priority Disease	Treatment/Procedure	Balance	Cost	Trans: Difference Slip#	Date	Amount	Pay

Admission:

Admission #	Date	Exp: Discharge	Attendant	Mobile #	Relation Authorized	Dated

System Generated: Manually

STATE LIFE
INSURANCE CORPORATION OF PAKISTAN

Program: **PMNHIP**

Manual Discharge Slip

Name of the HEAD of the Family: _____ Sehat Card No: _____

Patient Name: _____ Hospital Name: _____

Name of the Disease: _____

Date of Admission: _____ Date of Discharge: _____

Discharge Type: _____

	Very Good	Good	Fair	Bad	Very Bad
Behavior of SLIC HFO:					
Behavior of Hospital Staff:					
Nature of Treatment Provided by Hospital:					
Nature of Cleanliness of Hospital:					
Facilities regarding food items					

If Non – Satisfactory, Reason: _____

Your Suggestions in this Regard: _____

Contact No: _____ Patient / Relative Signature: _____

Hospital Management to Above Mentioned / Patient Given Transport Charges (_____ 350/-)

_____ _____

Hospital Officer Signature

Sign / Thumb Impression
(Received BY)

State Life Insurance Corporation of Pakistan

Health & Accident Insurance Division

PRE-REQUISITE FOR CLAIM SUBMISSION

Hospital Name: _____

Visit No: _____

Admission Date: _____

Discharge Date: _____

1. Copy of PMNHP "Sehat Card"? Yes ☐ No ☐
2. Copy of CNIC? Yes ☐ No ☐
3. Copy of B-Form (for less than 18 years) Yes ☐ No ☐
4. Hospital Treatment Sheet? Yes ☐ No ☐
5. Hospital Discharge Slip? Yes ☐ No ☐
6. State Life Referral Letter? Yes ☐ No ☐
7. State Life Case Sheet attached? Yes ☐ No ☐
8. State Life Discharge Slip? Yes ☐ No ☐
9. Rs.350/- Payment receipt Verified by HFO? Yes ☐ No ☐
10. 5 days post Discharge medicine duly verified by HFO? Yes ☐ No ☐

_____	_____	_____	_____
STAMP (HFO)	CHECKED BY (DMO)	VERIFIED BY (PMO)	DATE